# Michigan Department of Health and Human Services (MDHHS)

## Michigan Drug Assistance Program (MIDAP)

## Hepatitis C/HIV Prior Authorization Request Form

The information on this form will be used in determining eligibility for the Michigan Drug Assistance Program's (MIDAP) HIV/HCV Treatment Assistance. A limited number of treatment slots are available (dependent upon available funding) for uninsured clients or whose insurance does not cover needed HCV medications. All questions must be completed, required documents much be attached, and the form must be signed by the client's medical provider applying for this assistance.

**Criteria for enrollment in this program are:**

- Provider compliance with the American Association for the Study of Liver Disease (AASLD) guidelines in the treatment of HIV/HCV coinfected patient http://www.hcvguidelines.org/full-report-view, and http://www.hcvguidelines.org/ https://www.hcvguidelines.org/unique-populations/hiv-hcv

| **Patient Information** | |
|---|---|
| Last Name: _____ | First Name: _____ |
| MIDAP ID: _____<br>Social Security Number: _____<br>Date of Birth: _____/_____/_____<br>Gender: ☐ Male ☐ Female | Address: _____<br>City: _____<br>State: MI Zip: _____<br>Phone Number: _____ |

| **Prescriber Information** | |
|---|---|
| Last Name: _____ | First Name: _____ |
| NPI Number: _____<br>Phone Number: _____<br>Fax Number: _____ | Address: _____<br>City: _____<br>State: MI Zip: _____ |

Prescribers Specialty *(The prescriber must be a GI, ID specialist or a Hepatologist, otherwise collaboration/consultation is required).*

**Indicate Specialty:** ☐ Gastroenterologist ☐ Hepatologist ☐ Infectious Disease Specialist

**For providers not identified above:** If the prescribing provider is not one of the above listed specialists, it is expected the prescriber has collaborated / consulted with one of the above noted specialists. Please identify the specialty of the prescriber: ☐ Internal medicine ☐ Family medicine ☐ NP ☐ PA

☐ Other, Please Specify: _____

Consulting/collaborating specialist name: _____

In addition, please include supporting documentation that demonstrates consultation/collaboration with the specialist (e.g., consult notes, progress notes, plan of care, including dates noted)

| Pharmacy Information | |
|---|---|
| Name of Pharmacy: _____ | |
| Phone Number: _____ | Fax Number: _____ |

| Clinical Criteria Documentation | | |
|---|---|---|
| 1. Does the patient have a diagnosis of HIV? | ☐ Yes<br>CD4 Count: _____<br>Viral Load: _____ | ☐ No |
| 2. Has the patient had prior treatment for Chronic Hepatitis C? ☐ Yes ☐ No<br>2a. If yes, provide date(s) of treatment: _____ _____<br>2b. Treatment regimen used: _____ | | |
| 3. Check HCV Genotype:<br>☐ Genotype 1 ☐ Genotype 4<br>☐ Genotype 1a ☐ Genotype 5<br>☐ Genotype 1b ☐ Genotype 6<br>☐ Genotype 2 ☐ Chronic Hepatitis C, mixed genotypes: _____ _____ _____<br>☐ Genotype 3 ☐ Hepatocellular Carcinoma awaiting liver transplant<br>☐ without cirrhosis ☐ compensated cirrhosis body weight: _____ lbs. | | |
| 4. Does the patient have hepatocellular carcinoma? | ☐ Yes | ☐ No |
| 5. Metavir Fibrosis Score **(attach documentation)**<br>Date: _____ | ☐ Unknown<br>☐ F0<br>☐ F1<br>☐ F2 | ☐ F3<br>☐ F4<br>☐ F5<br>☐ F6 |
| 6. Baseline HCV Viral Load **(attach documentation)** | Date: _____ | |
| 7. Hepatitis A Serology **(attach documentation)**<br>7a. HAV Results ☐ Positive ☐ Negative | 8. Hepatitis B Serology **(attach documentation)**<br>8a. HBsAg Results ☐ Positive ☐ Reactive<br>8b. Anti-HBs or HBsAB Results ☐ Positive ☐ Reactive<br>8c. Anti-HBc or HBcAB Results ☐ Positive ☐ Reactive | |
| 9. Child-Pugh Score | Points: _____ | ☐ A<br>☐ B<br>☐ C |
| 10. PT/INR Values: _____ | 11. Bilirubin: _____ | |
| 12. What is the current (within the last 90 days) renal function (creatinine clearance or GFR, estimated) | _____ mL/min | |
| 13. Are the patients CBC **results attached** and within the last 90 days? | ☐ Yes Date: _____ | ☐ No |
| 14. Are the patients AST/ALT **results attached** and within the last 90 days? | ☐ Yes Date: _____ | ☐ No |
| 15. Is a recent (within 90 days) urine or blood test for illicit drugs and alcohol attached? **Results must be attached.** | ☐ Yes | ☐ No |

| | | |
|---|---|---|
| 15a. If positive results are present but are attributable to legally prescribed medications, please **attach the documentation** and explain the rationale for the positive results.<br>15b. If positive results are present but cannot be attributed to legally prescribed medications, please indicate whether the patient is actively attending or has been referred to a treatment program for substance abuse. This applies for any positive test results for alcohol, illicit substances, or prescription drugs for which the patient does not have a prescription. **(attach documentation)** | ☐ Positive; attending treatment program<br>☐ Positive; referred to treatment program<br>☐ Positive; not attending/referred to treatment program | |
| 16. Is a current list of all the patient's medications attached? **(attach documentation)** This list should include all scheduled maintenance and as needed (PRN) medications the patient will be taking while on HCV therapy. | ☐ Yes | ☐ No |

## Medication Selection: Indicate the genotype and treatment regimen being requested

| **EPCLUSA®** (sofosbuvir/velpatasvir) | | | |
|---|---|---|---|
| Check genotype & treatment regimen | Patient Population | Treatment | Duration |
| | **Genotype 1, 2, 3, 4, 5, or 6** without cirrhosis or with compensated cirrhosis | Epclusa® | 12 weeks |
| http://www.gilead.com/~/media/files/pdfs/medicines/liver-disease/epclusa/epclusa_pi.pdf?la=en | | | |
| **HARVONI®** (ledipasvir/sofosbuvir) | | | |
| Check genotype & treatment regimen | Patient Population | Treatment | Duration |
| | **Genotype 1:** Treatment-naïve w/out cirrhosis who have pre-treatment HCV RNA less than 6mil IU/ml and HIV co-infected | Harvoni® | 12 weeks |
| | **Genotype 1:** Treatment-naïve w/out cirrhosis or with compensated cirrhosis | Harvoni® | 12 weeks |
| | **Genotype 1:** Treatment-experienced w/out cirrhosis | Harvoni® | 12 weeks |
| | **Genotype 1:** Treatment-experienced with compensated cirrhosis | Harvoni® | 24 weeks |
| | **Genotype 4, 5, or 6:** Treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis | Harvoni® | 12 weeks |
| http://www.gilead.com/~/media/Files/pdfs/medicines/liver-disease/harvoni/harvoni_pi.pdf | | | |
| **MAVYRET™** (glecaprevir/pibrentasvir) | | | |
| Check genotype & treatment regimen | Patient Population | Treatment | Duration |
| | **Genotypes 1, 2, 3, 4, 5, or 6:** without cirrhosis | Mavyret™ | 8 weeks |
| | **Genotypes 1, 2, 3, 4, 5, or 6:** with compensated cirrhosis | Mavyret™ | 12 weeks |
| http://www.rxabbvie.com/pdf/mavyret_pi.pdf | | | |
| **ZEPATIER®** (elbasvir/grazoprevir) | | | |
| Check genotype & treatment regimen | Patient Population | Treatment | Duration |
| | **Genotype 1a:** Treatment-naïve or peg-interferon/RBV experienced without baseline NS5A polymorphism | Zepatier® | 12 weeks |
| | **Genotype 4:** Treatment-naïve | Zepatier® | 12 weeks |
| http://www.merck.com/product/usa/pi_circulars/z/zepatier/zepatier_pi.pdf | | | |

Submit Requests to:
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